STATE MINNESOTA

lease or rental payments, and the investment allowance for proprietary providers. The freeze on property related costs expires on June 30, 1985. At that time, the State must have developed a new system to reimburse property related costs.

Some exceptions to the property related cost freeze are possible for facilities whose property related costs are below the average property related costs of all facilities in a given group. (See Supplement 1, page 31.)

-11 NO 84-31 Rec'd 9/28/84
X Approved 11/14/84 - EFF 7/1/84
☐ Denied ☐ Do not sp
Date

operating cost payment rate shall be based on each facility's allowable historical cost incurred during the reporting year immediately preceding the rate year for which the operating cost payment rate is effective increased by the Consumer Price Index.

In addition, all facilities receive $.27 per resident day as an operating cost adjustment allowance.

B. If a facility is able to keep its operating costs below the operating cost payment rate, the facility may keep the difference as an efficiency incentive. One-half of the efficiency incentive will be added to the facility's historical base for the following year. Any adjustments subsequent to the final desk audit rate will not be eligible for this incentive.

Property-Related Costs

Classification

Property related costs include depreciation allowance, capital loan interest expense, special assessments, and accrued real estate taxes, rental and lease payments, amortization, and related organization property costs.

Limitations

A. Changes in Ownership:

Adjustments to the historical capital cost of assets due to changes in ownership are not allowed.

B. Allowable Interest; the new rule limits interest expense as follows:

1. Interest expense for capital loans entered into prior to January 1, 1984 will be allowed as recognized under the prior rule.

2. For capital loans entered into after December 31, 1983:

- Interest expense increases due to changes in ownership or the refinancing of a capital loan

OFFICIAL

SUPPLEMENT 2

July 1, 1985

STATE OF MINNESOTA

COUNTY OF RAMSEY

MINNESOTA DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED RULES OF THE MINNESOTA DEPARTMENT OF HUMAN SERVICES RELATING TO DETERMINATION OF PAYMENT RATES FOR INTERMEDIATE CARE FACILITIES FOR PERSONS WITH MENTAL RETARDATION (MINNESOTA RULES, PARTS 9553.0010 - 9553.0080 [PROPOSED])

STATEMENT OF NEED AND REASONABLENESS

TABLE OF CONTENTS

HCFA-179 # 86-3 Date Rec'd 3-30-86

Supercedes _____ Date Appr. 7-22-86

State Reg. In V.2. Date Eff. 1-1-86

I. BACKGROUND

The proposed permanent rules (parts 9553.0010 to 9553.0080) governing rates for intermediate care facilities for persons with mental retardation, have been developed to implement Minnesota Statutes, section 256B.501, subdivisions 1 to 3. This legislation specifies that the Commissioner of Human Services shall establish by rule, procedures for determining rates for care of residents of intermediate care facilities for the mentally retarded. The legislation indicates that the rates should cover only "costs that must be incurred" in the care of residents in efficiently and economically operated facilities, and that in developing the procedures the commissioner shall include:

"(1) Cost containment measures that assure efficient and prudent management of capital assets and operating cost increases which do not exceed increases in other sections of the economy;

(2) Limits on the amounts of reimbursement for property, general and administration, and new facilities;

(3) Requirements to ensure that the accounting practices of the facilities conform to generally accepted accounting principles; and

(4) Incentives to reward accumulation of equity."

This legislation reflects the continuing concern of the citizens of Minnesota that care for the mentally retarded be provided in a cost-efficient manner that is consistent with quality care. The legislation further stipulates that in developing the rule, the commissioner shall consider the recommendations contained in the February 11, 1983, report of the Legislative Auditor entitled Evaluation of Community Residential Programs for Mentally Retarded Persons ("LAC Report", Exhibit A), and the recommendations contained in the 1982 Report of the Department of Public Welfare Rule 52 Task Force ("52 Task Force Report", Exhibit B). Information from these reports, as well as other sources comprise the background for this proposed permanent rule, which sets out procedures for determining the total payment rates for intermediate care facilities for the mentally retarded (ICFs/MR) participating in the Medical Assistance program. (See Exhibit C for a discussion of the Department's consideration of the above referenced reports.) The rule parts are proposed as a permanent rule to replace 12 MCAR §§ 2.0530-2.05315 [Temporary].

Major Needs

Major needs raised by the legislature, agency staff, providers, and client advocates, documented by the LAC Report or the 52 Task Force Report and addressed by this rule are:

1. The need to encourage the best possible care to mentally retarded persons within existing fiscal constraints. (52 Task Force Report, 1982: p. 4)

2. The need to control expenditures associated with ICF/MR services. (DHS Commissioner's Remarks, 1985, p. 5.)

3. The need to introduce fiscal accountability for the use of public funds in an industry which receives over $100 million in reimbursement from public sources. (DHS Commissioner's Remarks, 1985: p. 22)

4. The need to direct scarce state resources to areas of resident care rather than to administrative and property-related areas. (LAC Report, 1983: p. 35-36.)

5. The need to introduce financial stability given the high level of indebtedness of the industry. (LAC Report, 1983: p. 57-59.)

6. The need to clearly identify the costs currently included in the per diem in order to move towards a pricing system, and to evaluate care outcomes.

7. The need to contain cost increases in ICFs/MR in order to balance the needs of mentally retarded persons in ICFs/MR with the special service needs of the mentally retarded and other disabled persons in different settings. (52 Task Force Report, 1982: p. 4.)

In order to understand the genesis of the needs listed above, and their impact on this rule, it is necessary to examine the development and funding of the ICF/MR industry in Minnesota.

Development of the ICF/MR Industry

In Minnesota, the focus of residential care for the mentally retarded has shifted from state hospitals to community homes known as Intermediate Care Facilities for the Mentally Retarded or ICFs/MR. During the 1960s, over 6,000 mentally retarded persons lived in Minnesota state hospitals (LAC Report, 1983, p. 6). At the end of 1984, the state hospital population was under 2,100. A consent decree emanating from the case known as Welsch v. Levine, No. 4-72-451 (D. Minn. September 15, 1980), requires further reduction in state hospital populations. To meet this mandate, DHS has stressed transferring state hospital residents to ICFs/MR and has encouraged development of new ICFs/MR.

Minnesota is one of the highest state users of ICF/MR services in the nation. In fact, one-eighth of all the ICFs/MR in the nation are in Minnesota. Minnesota has more ICF/MR beds owned by for profit providers than any other state. In 1977, there were 170 community facilities in Minnesota. By the end of 1984, there were approximately 330 community

HCFA-179 # 86-3 Date Rec'd 3-20-86
Supercedes _____ Date Appr. 7-22-86
State Rep. In. 421 Date Eff. 1-1-86

facilities in Minnesota, certified to serve 5,150 children and adults.

Although the population of state hospitals in Minnesota continues to decline, the total number of mentally retarded persons in long-term residential care settings, both in state hospitals and in the community, has increased steadily in recent years. In 1978, the average population in hospitals and community facilities was approximately 6,300. (LAC Report, 1983, p. xi.) By June, 1985, it had increased to more than 7,100. The per capita (per 100,000 persons) utilization of state hospital and community-based ICF/MR beds in Minnesota has steadily increased from 146.9 in 1977 to 178 in 1985.

Besides state hospitals and ICFs/MR, persons with mental retardation are also served by three other types of long-term care programs. They are county supervised foster care homes, semi-independent living services (SILS) to retarded persons living in their own homes and apartments, and subsidy programs to assist families in caring for their mentally retarded children at home. Through this system, the state is attempting to develop an array of services which provides services for the mentally retarded person at a care level appropriate to their needs.

By 1983, there was growing evidence that the state had relied too heavily on the ICFs/MR for the care of persons with mental retardation. The development of new community ICF/MR beds had already passed the 1987 goals outlined in the Department of Human Services Six Year Plan. Staff of the Department of Human Services, the Department of Health, and ICF/MR providers estimated that 10 to 20 percent (500-1000) of community ICF/MR residents were ready for SILS or other independent settings. (LAC Report, p. 78.) During this same period of time the Governor's Planning Council on Developmental Disabilities also took a look at policy alternatives for serving persons with developmental disabilities during the 1980s and published their find-ings in Developmental Disabilities and Public Policy, A Review for Policy-Makers (January, 1983). This report and the LAC Report stressed the need to develop alternatives to ICF/MR care, but recognized that the development of service alternatives is directly linked to the availability of state and federal funding. As a means of addressing this problem both documents mentioned the Title XIX waiver process and the LAC report recommended that the state apply for a waiver under section 2176 of the federal Omnibus Budget Reconciliation Act of 1981. The waiver would enable Minnesota to receive the same rate of federal financial participation for providing an array of less costly home and community-based services as the rate for ICF/MR services, as long as the persons served would otherwise require placement in an ICF/MR.

The LAC recommendations were debated by the 1983 Legislature which then passed Chapter 312 of Laws of Minnesota, 1983. Chapter 312 authorized the commissioner of human services to apply for a Title XIX waiver to provide home and community-based services to persons with mental retardation and to promulgate emergency and permanent rules to implement the waiver. A moratorium on community-based ICF/MR beds was included in this legislation.

Minnesota's home and community-based waiver for people with mental retardation was approved in April, 1984, for a three year period (July 1, 1984 to July 1, 1987). The purpose of a home and community-based waiver for people with the mental retardation was to limit and reduce the use of intermediate care facilities for mentally retarded by providing an array of alternative services for people with mental retardation. Home and

community-based services are directed toward people with mental retardation who would otherwise remain in an ICF/MR if alternative services were not provided or people who are determined to be eligible and at risk of ICF/MR placement within one year.

The funding for home and community-based services are generated in two ways: medical assistance savings projected based on reducing ICF/MR caseloads and costs due to services being converted from ICF/MR to home and community-based services, and medical assistance savings projected based on limiting growth of ICF/MR caseloads and costs due to "diverting" persons from ICF/MR placement to home and community-based services. The state must demonstrate to the federal government that the cost of the total system including ICF/MR and home and community-based waiver services is equal to or less than the costs would have been without the waiver. Therefore, ICF/MR costs must be contained. The amount of funding available for the provision of home and community-based services is, therefore, directly related to the continuance of the ICF/MR moratorium and to effective costs containment in the ICF/MR reimbursement system. If the state is to continue to develop these alternatives, costs in state hospitals and ICFs/MR must be controlled.

Funding of the ICF/MR Industry

Since the early 1970s, federal matching funds through Medicaid have been provided to states to pay for care given by certified vendors to mentally retarded persons in state hospital programs, community residential facilities, and nursing homes. In accordance with federal provisions, Minnesota established a program to set payment rates for certified vendors. Prior to 1973, the program was administered by individual counties. In 1973, Rule 52 (Minnesota Rules 9510.0500 - 9510.0890 [1983]) was adopted in order to centralize the rate setting process for community based ICF/MR programs at the state level.

The development of the ICF/MR system has been costly on both the state and federal level. A 1984 study done by Health Care Financing Administration (HCFA) staff reported that on the federal level, Medicaid expenditures for ICFs/MR care have risen from $203 million in 1974 to $3.6 billion in 1982. (Short-Term Evaluation of Medicaid, 1984, pp. 9 and 62.) This study asserted that the increasing proportion of Medicaid expenditures spent on nursing homes is entirely attributable to growth in expenditures in ICFs/MR. In Minnesota, the state share of community-based ICF/MR expenditures was 15.9 million in fiscal year 1980. The state's share for fiscal year 1985 is projected to be 46 million.

In 1980 Congress determined that the Medicaid system in existence at that time was too dependent on Medicare methodology and inflation. (See Senate Finance Committee Report on H.R. 934. S. Rep. No. 95-471 and Senate Budget Committee Report on S.1377, S. Rep. No. 97-139). The Omnibus Budget Reconciliation Act of 1980 made a significant change in the provisions of the Medicaid law that governs payments for LTC facility services. Section 962 amended section 1902 (a)(13)(E) of the Social Security Act to remove the requirement that states pay for these services on a reasonable cost-related basis, and to substitute for it, the requirement that states pay for SNF and ICF services through the use of rates (determined in accordance with methods and standards developed by the state) which the state finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities....(See Section 962 of the Omnibus Budget Reconciliation

Act of 1980, Public Law 96-499 and Section 2173 of the Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, amending Section 1902(a)(13)(A) of the Social Security Act, 42 USC § 13).

As an incentive to encourage states to utilize their newly granted freedom to revise rate methodology, the Congress also imposed a reduction in federal financial participation (FFP) in Medicaid programs beginning in fiscal year 1982. Federal regulations, 42 CFR 433.205, reduced FFP by 3 percent for fiscal year 1982, 4 percent for fiscal year 1983, and 4.5 percent for fiscal year 1984. "The proposed reduction would shift financial responsibility for Medicaid costs from the federal government to the states by over $500 million in fiscal year 1985 and $3.3 billion over five years." (American Health Care Journal, March, 1984: p. 47-48.)

In examining the ICF/MR industry in Minnesota for specific ways that costs could be contained and services maintained, the LAC Report determined that there was a need to:

> Direct scarce resources to areas of resident care rather than to administrative and property related areas.
>
> Introduce financial stability given the high level of indebtedness of the industry.

Unless the state limits interest expense, restricts exorbitant leases, limits the amounts that can be paid to top management, and creates incentives for efficient management, property and administrative costs can be expected to continue to rise with no improvement in the quality of care residents receive.

Further, there is a high level of indebtedness within the ICF/MR industry itself (LAC Report, 1983, p. 55) Most new facilities are largely debt-financed. Providers have very little equity. Some facilities are indebted above the value of their fixed assets. Low equity can:

- Increase property costs and, thus, per diems;
- Burden a provider with high fixed costs, while limiting flexibility to deal with possible decreases in occupancy or Medicaid reimbursement; and
- Indicate that the provider is less committed to the facility and its program to the extent that low equity represents less financial commitment on the part of the provider. (LAC Report, p. 57)

The legislation authorizing the development of this rule directs the Department to develop incentives to reward accumulation of provider equity.

The state is interested in providing quality care to residents. The relationship of reimbursement to quality of resident care is difficult to determine currently because reimbursement is not directly related to resident need or care outcome. In fact, costs currently included in the per diem are not always identified in such a way that their relationship to resident care can be determined. Department research (Lewin and Associates, 1984) has determined that a "case mix" system which relates reimbursement rates directly to resident needs, is a workable system for reimbursement for nursing homes. The Department intends to have research done on the viability of a reimbursement system for the ICF/MR industry which is based upon a

case mix of resident needs and care outcomes. The legislature has authorized funds to conduct such research. The first step in moving to a reimbursement system more directly related to resident care is clear identification of costs so that their relationship to resident care can be established. This need is addressed in the proposed rule.

The policy consensus at both the federal and state level is that limited resources must be targeted to an array of services if we are to provide quality care for persons with mental retardation in the least restrictive environment consistent with their care needs. The intermediate care facility is integral to the service strategy for care for persons with mental retardation in Minnesota. However, the ICF/MR industry has now mushroomed to the point that it is projected that they will receive $10,000,000 for fiscal year 1985 in reimbursement from public sources. If the state is to encourage an array of services to best meet the needs of the persons with mental retardation, public investments in ICF/MR services must be carefully targeted to achieve maximum benefit to the residents within the constraints imposed by limited resources. State reimbursement rules, as explained below are major tools for allocating resources and for cost containment.

Rule History

DHS Rule 52 was the initial rule which defined the process and formula for setting per diem rates for Medicaid recipients in intermediate care facilities for the mentally retarded. This rule was adopted in 1973 and went through a number of revisions before it was replaced with 12 MCAR §§ 2.0530 - 2.05315 (Rule 53 [Temporary]), in 1984.

Under Rule 52, each provider's per diem rate for the upcoming year was based upon a determination of actual allowable costs from the previous year plus projections for known or anticipated cost changes.

The reimbursement procedures developed in Rule 52 came under criticism from both providers and the legislature. Providers complained about its lack of clarity. The report of the legislative auditor documented the rule deficiencies and the resulting mushrooming of expenditures taking place under the rule.

Given this background, and in response to the 1983 legislative mandate, the department began work on first a temporary and then a permanent rule to replace Rule 52. The Department developed the temporary rule (12 MCAR §§ 2.0530-2.05315) after considering the analysis of Rule 52 in the 1983 report of the legislative auditor (Evaluation of Community Residential Program for Mentally Retarded Persons; 1983), and the work of the Rule 52 Task Force. This rule became effective on January 1, 1984. The rule introduced measures to contain property costs such as elimination of rebasing of assets on sales, interest rate limits, incentives to renegotiate high interest loans, and a 20 percent down payment requirement for acquisition of new capital assets. The rule also required facilities to put aside depreciation payments in a funded depreciation account so that, in the future, when the principal payments on the provider's mortgage increase, money will be available to meet these obligations.

Major changes in operating cost reimbursement under 12 MCAR §§ 2.0530-2.05315, were that known cost changes were eliminated and replaced with straight indexing, top management compensation was limited, and incentives for efficient management were included.

HC ... Date Rec'd 5-30-85
Superc ... Date Appr. 7-22-85
State Rep. In. 4-2, Date Eff. 1-1-86

The proposed permanent rule builds on the foundations of the temporary rule. It also incorporates procedures and methods developed for the nursing home reimbursement rule (Minnesota Rules, parts 9549.0010 to 9549.0080, commonly referred to as Rule 50) in those areas where the two types of facilities are similar. Rule 50 has already been through the public hearing process and has been found to be a necessary and reasonable way of setting rates for nursing homes. The report completed after that public hearing

> (Report of the Administrative Law Judge in the matter of the Proposed Adoption of Department of Human Services Rules Governing Payment Rates for Nursing Homes Licensed Under Minnesota Statutes, Chapter 144A or Boarding Care Facilities Licensed Under Minnesota Statutes, Section 144.50 to 144.58 Participating in the Medical Assistance Program, HS-85-036-JL, May 7, 1985, Jon L. Lunde, Administrative Law Judge.)

will be referred to in this SNR as the Lunde Report. The nursing home reimbursement rule (parts 9549.0010 to 9549.0080) will be referred to as Rule 50. Specific rationales for procedures and methods contained in the proposed ICF/MR reimbursement rule, and their relationship to the needs outlined at the beginning of this section, are explained in the body of this report.

Public Input

An advisory committee composed of representatives of the ICF/MR industry, consumer groups, county representatives and other people knowledgeable about ICF/MR financing, worked with the Department to develop the permanent rule. (See Exhibit D identifying members of the advisory committee and meeting dates.) This group met regularly throughout the rulemaking process and reviewed succeeding drafts of the rule. Their deliberations were considered throughout the rule development process. To garner even wider input, all providers were sent a letter asking them to review the draft rule in April, 1984. Over 300 copies of the proposed rule were sent out for comment, and the comments have been carefully reviewed by Department staff. This public input has proved to be a valuable resource in developing the rule.

II. SCOPE AND STATUTORY AUTHORITY - Part 9553.0010

Part 9553.0010 states the scope of parts 9553.0010 to 9553.0080. The proposed rule applies to intermediate care facilities for persons with mental retardation participating in the Medical Assistance Program, except state owned facilities. It is necessary to state the scope of the rule so that providers and other interested persons can determine whether the rule applies to them. The rule is effective for rate years beginning on October 1, 1986 according to part 9553.0010, because that is the date of the beginning of the first rate year after adoption of the rule.

The proposed parts were promulgated according to the requirements of federal statute 42 USC 1396 (a)(13)(A), Federal regulations 42 CFR Part 447 and Minnesota Statutes, Section 256B.501, subdivision 3. The separate reimbursement of state hospitals is specified in Minnesota Statutes, section 246.5, subdivision 5. These parts are enacted pursuant to the procedures set out in the Minnesota Administrative Procedure Act, Minnesota Statutes, sections 14.01 to 14.38.